

# Medical Approval to Exercise



Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

The above named patient would like to participate in Project Healthy Bones, an exercise and educational program designed to prevent and slow the development of osteoporosis. The program is led by trained Peer Leaders.

**The exercises are designed to improve balance and strength with the use of ankle and hand weights. Participants begin with 1 lb. weights and progress as self-determined.**

Project Healthy Bones is based on a program developed by the Massachusetts Department of Public Health and Action for Boston Community Development, Inc. in consultation with the Nutrition and Exercise Physiology Laboratory at Tufts University. The program is sponsored by the New Jersey Department of Human Services, Division of Aging Services. For more information on Project Healthy Bones, visit [www.state.nj.us/humanservices/doas/services/phb/index.html](http://www.state.nj.us/humanservices/doas/services/phb/index.html).

\_\_\_\_\_ **YES**, I approve and support my patient's participation in this progressive weight and balance training program.

\_\_\_\_\_ **NO**, my patient is not eligible to participate in this exercise program due to his/her current medical status.

\_\_\_\_\_  
Physician Signature\_\_\_\_\_  
Date

## PHYSICIAN INFORMATION:

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

**Please return this completed form to your patient.**